

**GEORGIA STATE BOARD OF WORKERS' COMPENSATION****NOTICE OF REPRESENTATION OF ANY PARTY  
OTHER THAN A CLAIMANT OR EMPLOYEE BY AN ATTORNEY**

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
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**A. IDENTIFYING INFORMATION**

<b>EMPLOYEE</b>	County of Injury		Address		
Employee E-mail			City	State	Zip Code
<b>ATTORNEY FOR EMPLOYEE / CLAIMANT</b>	Name		<b>EMPLOYER</b>	Name	
Address			Address		
City		State	Zip Code	City	State Zip Code
GA Bar number			Employer E-mail		
Attorney E-mail			<b>INSURER / SELF-INSURER</b>	Name	
<b>PARTY AT INTEREST</b>	Name		<b>CLAIMS OFFICE</b>	Name	
Address			Address		SBWC ID # (five digit no.)
City		State	Zip Code	City	State Zip Code
Party E-mail			Claims E-mail		

**B. NOTICE**

This serves notice that Attorney: _____					
of the firm: _____					
at mailing address: _____					
Telephone Number		City		State	Zip Code
Fax Number		E-mail Address			GA Bar Number
Is counsel in this case for the following named party / parties: _____					

**C. CERTIFICATION**

<input type="checkbox"/> I certify that I have today sent a copy of this form to all parties named above and to the State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, GA 30303-1299		
Signature	E-mail Address	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwgc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).